PRINTED: 10/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15G493	B. WIN	G			C 7/2011
	OVIDER OR SUPPLIER	A		41	EET ADDRESS, CITY, STATE, ZIP CODE 160 N CAMPBELL AVE IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORPREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		.D BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	investigation of complaint	W	000			
	#IN00096738. Complaint #IN000967 Federal/state deficient allegation(s) are cited W125, W149, W154, W240. Dates of Survey: 09/109/23/11 and 09/27/1 Facility Number: 0010 AIMS Number: 10024 Provider Number: 156 Surveyor: Robert Bauermeister, Leader	738: Substantiated, acies related to the lat W102, W104, W122, W156, W159, W218 and 19/11, 09/20/11, 09/22/11, 1					
W 102	Supervisor, RN These deficiencies al accordance with 460 Quality Review comp Shackelford, Medical 483.410 GOVERNING MANAGEMENT The facility must ensubody and management	so reflect state findings in IAC 9. leted 10/4/11 by Ruth Surveyor III.	W	1102			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	:		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I v /			(X3) DATE SURVEY COMPLETED		
		15G493	B. WIN	G			7/ 2011	
	COVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 160 N CAMPBELL AVE NDIANAPOLIS, IN 46220	0912	772011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
W 102	sampled clients (A, B the Condition of Partic The governing body for met the Condition of Protections in that the written policy and propand notify the Nurse as issues. The governing thorough investigation injuries of unknown so Nurse was notified of ingestion, followed by Findings include: 1. The facility's governing the facility met the Condition of the facility met the Condition of the facility met the Condition of the report of injuries of the report of the incidity or designee the result unexpected death of the report of the incidity indicating when/how the gait belt, wheelchair and Please see W122.	the facility failed to meet cipation: Governing Body. ailed to ensure the facility Participation of Client afacility failed to implement cedures to prevent neglect about specific client medical g body failed to ensure: (1.) as were conducted of purce (A, B) and (2.) a an incident of milk aromiting and falls. Thing body failed to ensure andition of Participation of that the governing body applicy and procedures to meet the needs of clients A tifying the facility nurse ingesting milk, vomiting and e kitchen, (2.) conducting as of client A's and B's 4 anknown source and client to the report to the Administrator and so of an investigation of the client A within 5 work days of ent, (4.) restricting client B's andicating the need for the ving instructions for staff to implement the use of the	W	102				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED		
		15G493	B. WING				7/ 2011	
	OVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL 4160 N CAMPBELL AVE INDIANAPOLIS, IN 46220	DE	09/2	7/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION) T,			X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE			
W 102	and procedures to proper and B. The governing general policy and optical facility to ensure the finvestigations, report investigations to the facility and reported issues to review and follow up. This federal tag relates #IN00096738. 9-3-1(a) 483.410(a)(1) GOVE	plemented its written policy event neglect of clients A g body failed to exercise perating direction over the facility conducted thorough ed the results of Administrator or designee to the nurse needing medical Please see W104.	w ·					
	Based on interview a Incident Initial Injury I investigative reports a governing body failed and operating direction the facility implement procedures to preven body failed to exercise operating direction on facility conducted the results of Administrator or designation of the conductive of the results of the conducted the conducte	affecting clients A and B, the I to exercise general policy on over the facility to ensure ed its written policy and t neglect. The governing e general policy and ver the facility to ensure the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15G493	B. WIN	IG		C 09/27/2011		
	ROVIDER OR SUPPLIER	4	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 1160 N CAMPBELL AVE NDIANAPOLIS, IN 46220			
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W 104	The facility Operation dated 06/12/07 was reply. The Operation State duty of the qualifical alleged incidents of all exploitation or injuries investigated within 5 callegation was made initiated" The facility Operation Reporting and Prever Exploitation," dated 0 09/22/11 at 2:30 PM. defined "Emotional/PI Failure to meet the baprovide a safe enviror Standard further indicated by (Age The facility Operation undated, was reviewed The Operation Standard following is a list of ponurse 5. persistent Any falls 20 Allow or neglect" The governing body fand procedures for 5 Reports and 1 of 4 inclients A and B. The gimplement its policy an eglect and meet the not: (1.) notifying the ingesting milk, vomiting the kitchen, (2.) conditions.	Standard, "Investigations," eviewed on 09/22/11 at 2:15 candard indicated, " It is ed person to: 3 Ensure ouse, neglect, mistreatment, of unknown origin are fully calendar days from the date and investigation was Standard, "Detection, of the of Abuse, Neglect or 19/14/07 was reviewed on The Operation Standard of the Operation Standard of the Operation Standard of the Operation ated, "A full investigation will ency Name) personnel." Standard, "Nurse on Call," and on 09/22/11 at 2:45 PM. and indicated, "A. The possible reasons to page the nausea or vomiting 14. and indicated, "A. The operations of physical abuse of 7 Incident Initial Injury oversigative reports affecting poverning body failed to and procedures to prevent needs of clients A and B by facility nurse about client B and and later falling twice in	W	104				

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W 104	to the Administrator of investigation of the unwithin 5 work days of (4.) restricting client Eindicating the need for having instructions for to implement the use and helmet. Please so This federal tag relater #IN00096738. 9-3-1(a) 483.420 CLIENT PRO	ng milk, (3.) failing to report or designee the results of an expected death of client A if the report of the incident, B's liquid intake without or the restriction and (5.) or staff indicating when/how of the gait belt, wheelchair see W149. The complaint of the results of the gait belt, wheelchair see to complaint		122			
	This CONDITION is Based on interview a Incident Initial Injury F investigative reports a facility neglected to m Participation: Client F to implement its polic neglect and meet the not: (1.) notifying the client B ingesting milk twice in the kitchen, (investigations of clien injuries of unknown s determine if neglect of failing to report to the the results of an investigations.	not met as evidenced by: and record review for 5 of 7 Reports and 1 of 4 affecting clients A and B, the					

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	ROVIDER OR SUPPLIER	A	416	ET ADDRESS, CITY, STATE, ZIP CODE 0 N CAMPBELL AVE DIANAPOLIS, IN 46220		
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W 122	without indicating the (5.) having instruction when/how to impleme wheelchair and helms. Findings include: 1. The facility, for 5 or Reports and 1 of 4 in clients A and B, negle and procedures to proneeds of clients A and facility nurse about clients and later fall conducting thorough of unknown source at milk, (3.) failing to represent the results of death of client A within of the incident, (4.) resintake without indicating when/how gait belt, wheelchair at W149. 2. The facility, for 5 or failed to conduct thorough of the incident	and client B's liquid intake need for the restriction and as for staff indicating ent the use of the gait belt, et. If 7 Incident Initial Injury exestigative reports affecting exted to implement its policy event neglect and meet the d B by not: (1.) notifying the ient B's ingesting milk, ing twice in the kitchen, (2.) investigations of the injuries not vomiting after ingesting fort to the Administrator or of an investigation of the noticity of the event and the need for the eving instructions for staff to implement the use of the and helmet. Please see If 7 reportable incidents, bough investigations of client are of unknown source and the termine if neglect was a lease see W154. If 4 investigative reports, the sto the Administrator or of an investigation of the notice of the report work days of the report	W 122			

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		15G493					7/0044
	ROVIDER OR SUPPLIER	L		41	EET ADDRESS, CITY, STATE, ZIP CODE 160 N CAMPBELL AVE NDIANAPOLIS, IN 46220	09/2	7/2011
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
W 122	failed to indicate their restricted to 6 to 8 glad Please see W125. 5. The Qualified Ment Designee (QMRPD), sample (B), the failed notified as required by the client's ingestion of falls, (2.) client B's fall the Individual Supportstaff were to assist clients.	f 4 sampled clients (B), reason for client B's being asses of fluid per day. Ital Retardation Professional for 1 of 4 clients in the ensure: (1.) the nurse was y facility policy/practice of of the milk, vomiting and ls were assessed and (3.) the Plan (ISP) included how ent B in the use of a gait elchair. Please see W159.	W	1122			
W 125	Therefore, the facility individual clients to ex of the facility, and as including the right to to due process. This STANDARD is r Based on interview a sampled clients (B), t client B to exercise he	ure the rights of all clients. must allow and encourage kercise their rights as clients citizens of the United States, file complaints, and the right not met as evidenced by: and record review for 1 of 4 the facility failed to assist er rights by not indicating the ing restricted to 6 to 8	w	125			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
15G493	B. WING		C 09/27/2011	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	4	REET ADDRESS, CITY, STATE, ZIP CODE 1160 N CAMPBELL AVE NDIANAPOLIS, IN 46220	03/2//2011	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
Continued From page 7 Findings include: Client B's records were reviewed on 09/22/11 at 1:00 PM. Client B's records were reviewed on 09/22/11 at 1:00 PM. Client B's diagnoses included, but were not limited to Profound Mental Retardation, Seizure Disorder, but did not include Polydipsia (excessive thirst and fluid consumption). The Physician's Orders, dated 09/01/11 indicated client B had a "Fluid Restriction, 6-8 glasses of fluid per day. Encourage single servings." The record did not contain any information on the reason for client B to have a fluid restriction. No records were available to indicate the Interdisciplinary Team had met and discussed the reason for the fluid restriction on at least an annual basis. The Nurse indicated on 09/22/11 at 2:15 PM that client B was on a fluid restriction. The Nurse stated, when asked why client B's fluids were restricted, "It has always been like that." The nurse did not offer any additional information on the reason for the fluid restriction. On 09/22/11 at 4:15 PM, the Qualified Mental Retardation Designee (QMRPD) stated client B was on a fluid restriction and had been "for a long time." This federal tag relates to Complaint #IN00096738.	W 125			
W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit	W 149			

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		15G493	B. WING		09	/27/2011
	OVIDER OR SUPPLIER RPORATION OF INDIA	ANA	4160	T ADDRESS, CITY, STATE, ZIP COI ON CAMPBELL AVE IANAPOLIS, IN 46220	DE	
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W 149	Continued From pa mistreatment, negl	age 8 ect or abuse of the client.	W 149			
	Based on interview Incident Initial Injurinvestigative report facility neglected to procedures to preveneeds of clients A a facility nurse about vomiting and later conducting thoroug of unknown source milk, (3.) failing to designee the result death of client A wi of the incident, (4.) intake without indicrestriction and (5.) indicating when/ho gait belt, wheelcha	is not met as evidenced by: w and record review for 5 of 7 by Reports and 1 of 4 its affecting clients A and B, the orimplement its policy and ent neglect and meet the and B by not: (1.) notifying the client B's ingesting milk, falling twice in the kitchen, (2.) gh investigations of the injuries and vomiting after ingesting report to the Administrator or its of an investigation of the thin 5 work days of the report restricting client B's liquid cating the need for the having instructions for staff w to implement the use of the ir and helmet.				
	dated 06/12/07 wa PM. The Operation the duty of the qua alleged incidents o exploitation or injurinvestigated within allegation was madinitiated" The facility Operation Reporting and Previous PM. The facility Operation PM. The facility Oper	s reviewed on 09/22/11 at 2:15 in Standard indicated, " It is lified person to: 3 Ensure if abuse, neglect, mistreatment, ries of unknown origin are fully 5 calendar days from the date de and investigation was son Standard, "Detection, wention of Abuse, Neglect or d 09/14/07 was reviewed on				

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	ROVIDER OR SUPPLIER	A		4	REET ADDRESS, CITY, STATE, ZIP CODE 1160 N CAMPBELL AVE NDIANAPOLIS, IN 46220	03/2	772011	
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W 149	09/22/11 at 2:30 PM. defined "Emotional/Pl Failure to meet the baprovide a safe enviror Standard further indice be conducted by (Age The facility Operation undated, was reviewed The Operation Standard following is a list of ponurse 5. persistent Any falls 20 Allor neglect" The facility's reportabin investigations were reported. The review indicates (Bureau of Developm reports: Client B - Incident Inite 07/01/11 at 7:30 PM, due to error in comple "Staff noted four red/It diameter on her butto to describe how she is notified supervisors at " Client B - Incident Inite 09/06/11 at 3:40 AM, [client B] with a shown incontinence, staff (not under her upper right on her hands"	The Operation Standard hysical Neglect," as, " asic requirements such as hment." The Operation hated, "A full investigation will ency Name) personnel." Standard, "Nurse on Call," and on 09/22/11 at 2:45 PM. and indicated, "A. The basible reasons to page the nausea or vomiting 14. are all indicated abuse le incident reports and eviewed on 09/19/11 at 1:00 ated the following BDDS ental Disabilities Services) ial Injury Report, dated later changed to 08/01/11 ating the report, indicated black bruises, four inches in cks. [Client B] was not able sustained the injury. Staff and the nurse per protocol ial Injury Report, dated indicated, "While assisting	w	149				

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W 149	[client B] was having called 911 EMS (Emergarived and transported hospital emergency of treatment. ER (Emergated hospital emergency of the treatment. ER (Emergated hospital emergency of the treatment of th	indicated, "Staff noted that difficulty breathing and orgency Medical Services) and [client B] to the [local born] for evaluation and gency Room) personnel O2 (oxygen) saturation was expected. After receiving a chest admitted to [local hospital] or ther treatment [Client B] are ventilator on 9/12/11 at experiencing difficulty gen saturation dropped deteriorated through the last 3:52 PM" PM, the Qualified Mental of (QMRPD) indicated on client B took a gallon the refrigerator, took it to the milk from the container of the last 3:52 PM. It is made to the bottom of the container of the last 3:52 PM. It is made to the bottom of the container of the last 3:52 PM. It is made to the bottom of the last 3:52 PM. It is made to the bottom of the container of the last 3:52 PM. It is made to the bottom of the last 3:52 PM. It is made to the bottom of the last 3:52 PM. It is made to the bottom of the last 3:52 PM. It is made to the bottom of the last 3:52 PM. It is made to th	W	149				

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W 149	reviewed on 09/22/1 handwritten form sig client C had volunted B had received the bindicated client B ha 09/05/11 while trying kitchen. He also indi Professionals (DSP) falls. The QMRPD g. "Corrective Actions" time sheets for 09/05 reviewed on 09/22/1 time sheets indicated PM on 09/05/11. The QM "probably occurred a were present." Clier the milk and later vo client B were not inv part of review of eve B's death. The facility Operation undated, was review The Operation Standfollowing is a list of purse 5. persisten Any falls 20 Alor neglect" On 09/22/11 at 4:10 the Nurse had not be drinking incident or to 09/05/11. On 09/22/11 at 3:00 could not provide ad documenting the impression of the county of the county of the provide ad documenting the impression of the county of t	1 at 4:10 PM. The ned by the QMRPD indicated ered that he knew how client or uises on her body. Client C d fallen at least twice on to steal something out of the cated Direct Support #4 and #7 had witnessed the ave DSP #4 and #7 statements. The automated 5/11 and 09/06/11 were 1 at 4:05 PM. The automated d DSP #4 signed in at 4:00 DSP #7 signed in at 2:54 PM MRPD stated the falls after 4:00 PM when both staff in B's death, the ingestion of mitting and the bruises on estigated or documented as ints occurring prior to client on Standard, "Nurse on Call," and on 09/22/11 at 2:45 PM. It did indicated, "A. The cossible reasons to page the trausea or vomiting 14. It legations of physical abuse PM the QMRPD indicated een notified of the milk the falls occurring on	w	149			

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W 149	Operation Standards, or Exploitation," dated dated 06/12/07, "Nurs" "Detection, Reporting Neglect or Exploitation Client B's records we 1:00 PM. Client B's on the Imited to Profoun Seizure Disorder, but The Physician's Order client B had a "Fluid Ffluid per day. Encour Reinforcement Inventindicated in the Colur Potentially Reinforcin and c. Milk; "Very Murecord did not contain fluid intake or team dion the reason for clier restriction. The Nurse indicated of client B was on a fluid stated, when asked will has always been ling offer any additional in the fluid restriction. The review of client Believe and the fluid restriction. The review of client Believe and the fluid restriction. The review of client Believe and the fluid restriction.	"Reporting Abuse, Neglect d 06/12/07, "Investigations," se on Call," undated and and Prevention of Abuse, n," dated 09/14/07. The reviewed on 09/22/11 at liagnoses included, but were d Mental Retardation, did not include Polydipsia. The diagnoses of age single servings." The tory, dated 04/08/09 nn - Description of g Events, a. Coke, b. Juice ch" was checked. The an assessment of client B's scussion or any information	W	149			

Facility ID: 001007

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W 149	ambulatory and wheelextremely off A he since [client B] has he the since [client B] has he the record did not constaff when to impleme wheelchair and helms. The facility, for 5 of 7 to conduct thorough in and B's 4 reports of u B's death to determine the death. Please see the facility failed to report designee the results of death of client A within of the incident. Please This federal tag relates #IN00096738. 9-3-2(a) 483.420(d)(3) STAFF The facility must have violations are thorough investigation of the incidents, the conduct thorough investigation of the incidents, the conduct thorough investigation in the conduct thorough investigation.	nefit from a gait belt when alchair when her gait is elmet was recommended and two incidents of falling" Intain any instructions for ent the use of the gait belt, etc. reportable incidents, failed investigations of client A's inknown injuries and client e if neglect contributed to e W154. investigative reports, the to the Administrator or of an investigation of the in 5 work days of the report e see W156. es to complaint TREATMENT OF CLIENTS e evidence that all alleged hely investigated. not met as evidenced by: and record review for 5 of 7 the facility neglected to estigations of client A's and own injuries and client B's		149			
	death.	neglect contributed to the					

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	ROVIDER OR SUPPLIER	A	'	4160	T ADDRESS, CITY, STATE, ZIP CODE ON CAMPBELL AVE IANAPOLIS, IN 46220	-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 154	Findings include: The facility's reportab investigations were reports. The review indicated (Bureau of Developm reports: 1. Client A - Incident I 07/22/11 at 11:00 AM being taken to the result in the result in the provided in the result in the r	de incident reports and eviewed on 09/19 /11 at 1:00 ated the following BDDS ental Disabilities Services) Initial Injury Report, dated indicated, "[Client A] was troom by (day program staff ticed an abrasion on the Incident Initial Injury Report rec/cause of the injuries 11. In Injury Report, dated indicated, "Staff noted red ght shoulder, right elbow k. Staff on the scene were of these red areas" The Report did not indicate a njuries discovered on In Administrative Staff #1 lence investigations had ient A's injuries of unknown 07/22/11 and 07/23/11. In Client A's records were unal Support Program (ISP), ehavior Support Program I, did not provide evidence discovered on 07/22/11 and	W	154			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	x2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		15G493	B. WIN	B. WING		C 09/27/2011	
	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 160 N CAMPBELL AVE NDIANAPOLIS, IN 46220	<u> 09/2</u>	7/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE		
W 154	07/01/11 at 7:30 PM, due to error in comple "Staff noted four red/It diameter on her butto to describe how she is notified supervisors a "The Incident Initial It a source/cause of the 08/01/11. Client B - Incident Initi 09/06/11 at 3:40 AM, [client B] with a show incontinence, staff (no under her upper right on her hands" The Report did not indicat injuries discovered or Client B - Incident Init 09/06/11 at 10:55 AM [client B] was having called 911 EMS (Emergnoted and transporte hospital emergency retreatment .ER (Emergnoted that [client B's] 64% and intubated he X-Ray, [Client B] was for observation and fowas removed from the 7:40 AM and began e breathing and her oxy [Client B] condition demorning and she died	later changed to 08/01/11 eting the report, indicated black bruises, four inches in cks. [Client B] was not able sustained the injury. Staff and the nurse per protocol anjury Report did not indicate injuries discovered on ial Injury Report, dated indicated, "While assisting er after an incident of bit identified) noted bruises arm, on her right breast and e Incident Initial Injury e a source/cause of the in 09/06/11. ial Injury Report, dated , indicated, "Staff noted that difficulty breathing and ergency Medical Services) ed [client B] to the [local bom] for evaluation and gency Room) personnel (O2 (oxygen) saturation was er. After receiving a chest admitted to [local hospital] urther treatment [Client B] e ventilator on 9/12/11 at experiencing difficulty orgen saturation dropped eteriorated through the	w	154			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G493	B. WIN	G			C 7/2011
	OVIDER OR SUPPLIER	A	·	4160	T ADDRESS, CITY, STATE, ZIP CODE ON CAMPBELL AVE IANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 154	AM to BDDS. On 09/2 Qualified Mental Reta indicated on 09/05/11 gallon container of mi it to her room and dra of milk. The container When it was retrieved enough milk in it to co container, milk was sy residue of milk was of measured the milk ret indicated client B vom particles. The QMRPI had accompanied the the day programs, sho A Witness Statement reviewed on 09/22/11 handwritten form sign client C had volunteed B had received the br indicated client B had 09/05/11 while trying kitchen. He also indic Professionals (DSP) a falls. The QMRPD ga "Corrective Actions" s time sheets for 09/05/ reviewed on 09/22/11 time sheets indicated PM on 09/05/11 and I on 09/05/11.	dated 09/06/11 at 10:55 22/11 at 4:15 PM, the redation Designee (QMRPD) at 2:00 PM client B took a lk from the refrigerator, took nk milk from the container was one-half full of milk. from client B's room it had over the bottom of the billed on the floor and some in client B's clothes. No one reved. The QMRPD indicated on 09/06/11 she clients on the transport to be had sat next to client B. Form, dated 09/06/11, was at 4:10 PM. The ed by the QMRPD indicated red that he knew how client uises on her body. Client C fallen at least twice, on to steal something out of the ated Direct Support #4 and #7 had witnessed the ve DSP #4 and #7 tatements. The automated 11 and 09/06/11 were at 4:05 PM. The automated DSP #4 signed in at 4:00 DSP #7 signed in at 2:54 PM	W	154			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G493		B. WING		C 09/27/2011	
	ROVIDER OR SUPPLIER	A		41	EET ADDRESS, CITY, STATE, ZIP CODE 160 N CAMPBELL AVE IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETION DATE
W 154	reviewed. The ISP, do dated 04/09/11, did no unknown injuries discoup/06/11 had been the milk drinking incident thoroughly investigated staff and clients had been reviewed a reviewed and compiled and medical intervention.	PM client B's records were lated 04/08/11 and BSP not provide evidence the covered on 08/01/11 and noroughly investigated or the coroughly investigated or t	W	154			
W 156	The results of all inve	estigations must be reported or designated representative accordance with State law ays of the incident.	W	156			
	Based on interview a investigative reports, the Administrator or of Home Operations) the of the death of client a Findings include: The facility's reportable	and record review for 1 of 4 the facility failed to report to designee (Director of Group the results of an investigation A within 5 work days.					
		eviewed on 09/19/11 at 1:00 cated 1 investigation result the administrator or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUIL			С	
		15G493	B. WING	5	0:	09/27/2011	
	OVIDER OR SUPPLIER RPORATION OF INDIAN	A		STREET ADDRESS, CITY, STATE, ZIP CODE 4160 N CAMPBELL AVE INDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 156	07/31/11 at 9:35 AM in hospitalized 07/26/11 intracranial hemorrhal He was placed on a vaspirating emesis who (Emergency Medical 07/31/11 at 9:30 AM.) The investigative report on the investigative report of the investigative	ial Injury Report, dated ndicated, "[Client A] was with diagnoses of ge and Status Epilepticus. rentilator at admission after ille being cared for by EMS Service) he died on or the investigation was nd completed on 09/08/11. entation the Administrator or	W	156			
W 159	reviewed. The Individ and Behavior Suppor 06/06/11, did not provinvestigation results h Administrator. This federal tag relate #IN00096738. 9-3-2(a) 483.430(a) QUALIFIE PROFESSIONAL Each client's active tr integrated, coordinate qualified mental retar	es to complaint ED MENTAL RETARDATION eatment program must be ed and monitored by a	W	159			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15G493	B. WIN	B. WING		C 09/27/2011	
	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 1160 N CAMPBELL AVE NDIANAPOLIS, IN 46220	1 09/2	7/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 159	Based on interview a clients in the sample Retardation Profession failed to ensure: (1.) required by facility poingestion of the milk, client B's falls were as Individual Support Plawere to assist client E helmet and wheelchat Findings include: On 09/22/11 at 4:15 F Retardation Designed at the home during the 2:00 PM, indicated clicontainer of milk from her room and drank now milk. The container with When it was retrieved enough milk in it to container, milk was spresidue of milk was on measured the milk reindicated client B vom particles. The QMRPD not been notified, on ingestion or vomiting, the day. The QMRPD have been notified of the fall. A Witness Statement reviewed on 09/22/11 handwritten form signicient C had volunteed.	and record review for 1 of 4 (B), the Qualified Mental anal Designee (QMRPD) the nurse was notified as licy/practice of the client's vomiting and falls, (2.) assessed and (3.) the an (ISP) included how staff as in the use of a gait belt, ir. PM, the Qualified Mental as (QMRPD), who had been be incident on 09/05/11 at ant B took a gallon the refrigerator, took it to nilk from the container of as one-half full of milk. If from client B's room it had over the bottom of the boilled on the floor and some an client B's clothes. No one trieved. The QMRPD nited and it contained food D indicated the nurse had 09/05/11, of the milk or the falls occurring later in indicated the nurse should milk ingestion, vomiting and Form, dated 09/06/11, was	W	159			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15G493	B. WING			C 09/27/2011	
	OVIDER OR SUPPLIER	A	•	STREET ADDRESS, CITY, STATE, ZIP C 4160 N CAMPBELL AVE INDIANAPOLIS, IN 46220	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
W 159	09/05/11 while trying kitchen. On 09/22/11 at 2:30 Findicated the Nurse sithe milk drinking incidence on 09/05/11. The QMRPD, for 1 of to ensure client B's far a baseline number of and environmental in see W218. The QMRPD, for 1 of to ensure client B's Irrincluded how staff we use of a gait belt, help the second of the	I fallen at least twice, on to steal something out of the PM Administrative Staff #1 hould have been notified of dent and the falls occurring 14 sampled clients (B), failed alls were assessed providing falls, where falls occurred fluence on the falls. Please 14 sampled clients (B), failed advidual Support Plan (ISP) are to assist client B in the met and wheelchair. 15 sto complaint 16 IVIDUAL PROGRAM PLAN 17 unctional assessment must development. 18 and record review for 1 of 4 the facility failed to assessing a baseline of number of arred and environmental	W 2	159			
	Findings include:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15G493	B. WING			С	
NAME OF PF	ROVIDER OR SUPPLIER	150455		STREET ADDRESS, CITY, STATE, ZIP CODE	•	27/2011	
VOCA CO	RPORATION OF INDIAN	4		4160 N CAMPBELL AVE			
				INDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 218	Continued From page	21	W 2	218			
W 240	PM indicated she had unsteady gait. The Per Profile, undated, indic however, sometimes particularly after period activity. The Health CO4/08/11 indicated, "[incidents of falling to felt that she would be ambulatory and whee extremely off A has since [client B] has had the record did not coteam used to determine belt and wheelchair unwithin a time period, who possible environments on 09/22/11 at 4:15 FR Retardation Profession provide evidence of the falls or what was used recommend client B wheelch the second provide and the second provided pr	es to complaint VIDUAL PROGRAM PLAN m plan must describe to support the individual	W 2	240			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUII			С	
		15G493	B. WIN	G		09/2	7/2011
	ROVIDER OR SUPPLIER RPORATION OF INDIANA	4		4160	FADDRESS, CITY, STATE, ZIP CODE N CAMPBELL AVE ANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 240	This STANDARD is r Based on interview a sampled clients (B), tl Plan (ISP) failed to in assist client B in the u wheelchair. Findings include: The review of client B 1:00 PM indicated sh unsteady gait. The Pe profile, undated, indic however, sometimes particularly after perio activity." The Health (04/08/11 indicated, "[u incidents of falling or felt that she would be ambulatory and whee extremely off A he since [client B] has ha The record did not co staff on when to imple belt, wheelchair and h On 09/22/11 at 4:15 F Retardation Professio provide evidence of w	not met as evidenced by: and record review for 1 of 4 the client's Individual Support dicate how staff were to use of a gait belt, helmet and "s records on 09/22/11 at the had a gait belt due to her the erson Centered Planning tated, "[Client B] does, walk with an unsteady gait - the discording of prolonged seizure Care Addendum, Dated Client B] has had several tattempting to fall Team the inferit from a gait belt when the lichair when her gait is the limet was recommended and two incidents of falling" The intain any instructions for the ment the use of the gait the limet. The ment is gait belt when the Qualified Mental the limet below the staff should the gait belt, wheelchair and a	w	240			